IMMIGRANT HEALTH

The immigrant population, especially newly arrived persons and non-citizens, faces both language and cultural barriers to accessing health care services. Of the estimated 16.6 million foreign-born women in the U.S. in 2003, more than half (59.2 percent) were non-citizens (including documented and undocumented immigrants).[1]

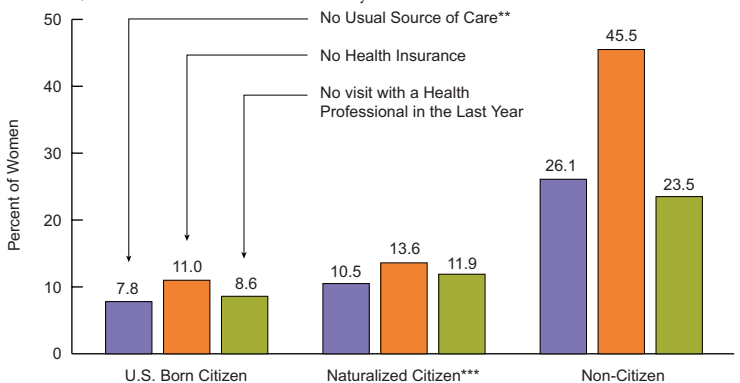
In 2003, women without U.S. citizenship were more likely than naturalized citizens or women born in the U.S. to lack a usual source of care (26.1 percent) and to lack health insurance (45.5 percent). The percentage without insurance decreased as length of time in the U.S. increased, although this trend was more evident among certain racial and ethnic groups. Non-Hispanic Black and Hispanic women who had been in the U.S. for less than 5 years had the highest uninsurance rates in 2003 (61.7 and 64.5 percent, respectively).

Foreign-born women were also less likely to have seen a health care professional within the last year. A greater proportion of non-citizen women (23.5 percent) had not seen a health professional in the past year compared to those born in the U.S. (8.6 percent).

1 *U.S. Census Bureau. Current Population Survey, Annual Social and Economic Supplement, 2003. August 2004. http://www.census.gov/population/socdemo/foreign/ppl-174/tab01-01.pdf*

Women Lacking a Usual Source of Care, Health Insurance and a Recent Visit with a Health Professional, by Citizenship Status,* 2003

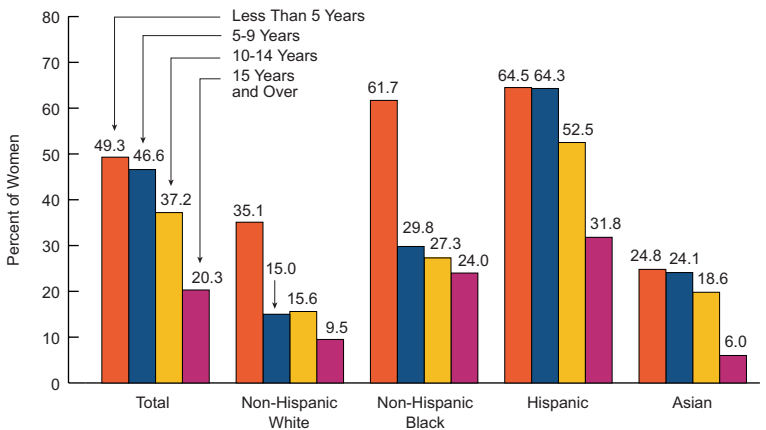
Source (II.2): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Percents are not age-adjusted.
**Defined as not having a place they usually go when sick.
***Person not born in the U.S., but holding U.S. citizenship.

Foreign-Born Women Without Health Insurance, by Length of Time in the U.S. and Race/Ethnicity,* 2003

Source (II.22): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Percents are not age-adjusted; Non-Hispanic women of other races are not shown due to small sample size.

BORDER HEALTH

Women along the U.S. side of the U.S.-Mexico border—within 100 kilometers, or 62 miles of the border—face many health disparities. More than one-third of families in the border region of the U.S. have incomes at or below the Federal poverty level. Because this population is likely to lack health insurance, access to health care is an important issue in this region. Approximately one-third of U.S. border residents reside in areas designated as Health Professional Shortage Areas for primary care.

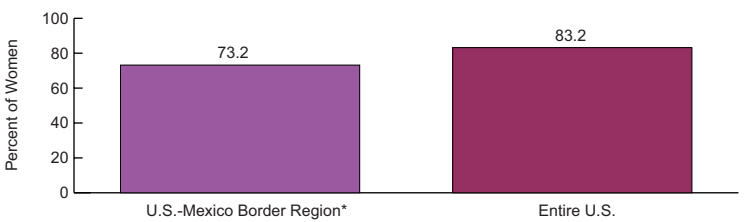
The quality of the air, water, and soil in the border region is another area of concern that can particularly affect the health of women (especially women of childbearing age) and children. Many households in the region are not connected to sources of clean water. The high level of industry and agriculture creates exposure to potentially harmful pesticides and other chemicals. Although there are few sources of data on these problems, the U.S.-Mexico Border Health Commission has among its objectives to reduce the proportion of households without complete bathroom facilities—in 2000, 1.1 percent of households on the U.S. side of the border had no complete bathroom facilities—and to reduce the number of hospitalizations as a result of pesticide poisoning.

In 2000, women in the U.S. border region averaged 2.5 children during their reproductive years, which is greater than the U.S. national average of 2.1. Despite the greater number of children born on the border, only 73.2 percent of women who gave birth received prenatal care during the first trimester, and only 64 percent received adequate care with regard to timing and number of prenatal visits compared to 83.2 percent in the U.S. as a whole during the same year.

Infectious diseases, including tuberculosis, hepatitis A, and hepatitis B, are also more prevalent in the border region than in the general U.S. population. In 2000, the incidence of tuberculosis in the border region was 10.0 cases per 100,000 people, compared to 6.0 per 100,000 people nationally. The rate of hepatitis A was 11.0 cases per 100,000 people in the border region, compared to 4.9 nationally, and the rate of hepatitis B was 6.3 cases per 100,000 persons, in the border region compared to 2.9 nationally.

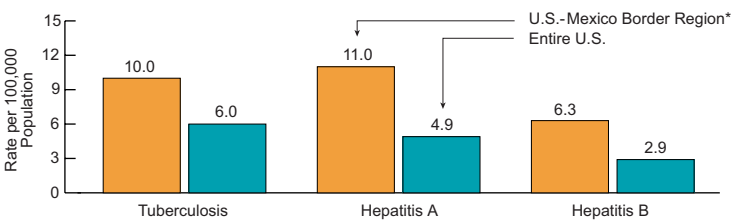
Pregnant Women Beginning Prenatal Care in the First Trimester, 2000

Source: (II.22) United States-Mexico Border Health Commission; Centers for Disease Control and Prevention, National Center for Health Statistics



Rates of Selected Infectious Diseases in the U.S.-Mexico Border Area, 2000

Source: (II.22) United States-Mexico Border Health Commission; Centers for Disease Control and Prevention, National Center for Health Statistics



*Includes 44 U.S. counties located within 100 kilometers north of the U.S-Mexico border excluding Maricopa, Pinal and La Paz counties in Arizona and Riverside County in California.

RURAL AND URBAN HEALTH

In 2000, 59 million people, or approximately 21 percent of the population, lived in a rural area.[1] Residents of rural areas tend to be older, poorer, less educated, have fewer health care providers and live farther from health care resources than their metropolitan counterparts. These issues increase special health concerns and barriers that can lead to poorer health, especially for women.

In 2002, women in non-metropolitan areas were more likely to be older than men in the same regions and than women in metropolitan areas. Among women living in non-metro areas, 17.3 percent were aged 65-90, compared to 13.8 percent of men in non-metro areas and 13.4 percent of metropolitan women.

Rural women were also more likely to report poorer health status than urban women. Of women in non-metro regions, 14.5 percent reported their health status to be fair or poor, a percentage that was not significantly different from men in the same areas, but was significantly higher than that of women in metropolitan areas (11.1 percent). Conversely, only 25.4 percent of non-metropolitan women described their health status as excellent, compared to 29.6 percent of non-metropolitan men and 29.9 percent of metropolitan women.

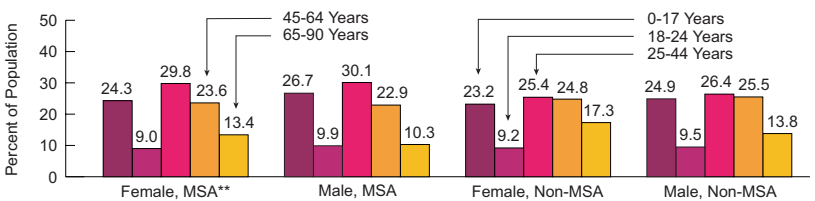
Women in non-metropolitan areas spend more on health care than their urban counterparts. The average annual health care expenditure for females in non-metropolitan areas was $3,358, compared to $2,949 for non-metropolitan males and $3,063 for metropolitan women.

HRSA's Office of Rural Health Policy (ORHP) maintains a wide range of programs to address the health of rural women. It supports the Rural Assistance Center, www.raconline.org, which has information on rural women's health and domestic abuse in rural areas. ORHP currently supports six community rural health outreach grantees throughout the U.S. that are addressing women's health and domestic violence issues. ORHP is also funding a study of poverty, parental stress, and violent disagreements in the home among rural families. Other research addresses the quality of women's care in rural health clinics.

1 *U.S. Census Bureau 2000. 2000 Summary File 1. Table P2. http://factfinder.census.gov/servlet/BasicFactsServlet.*

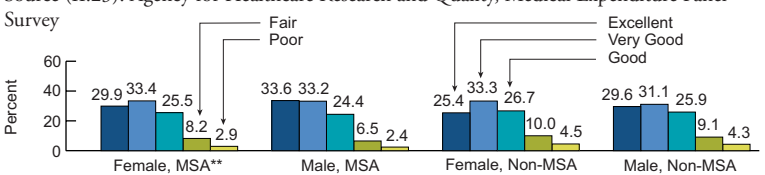
U.S. Population* by Age, Sex, and Area of Residence, 2002

Source (II.23): Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



U.S. Population* by Health Status, Sex, and Area of Residence, 2002

Source (II.23): Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



*Includes only the civilian, noninstitutionalized population.

**Metropolitan Statistical Areas (MSA) include at least: one city with 50,000 or more inhabitants, or a Census Bureau-defined urbanized area (of at least 50,000 inhabitants) and a total metropolitan population of at least 100,000 (75,000 in New England). Additional "outlying counties" are included in the MSA if they meet specified requirements of commuting to the central counties and other selected requirements of metropolitan character. In New England, the MSAs are defined in terms of cities and towns rather than counties.

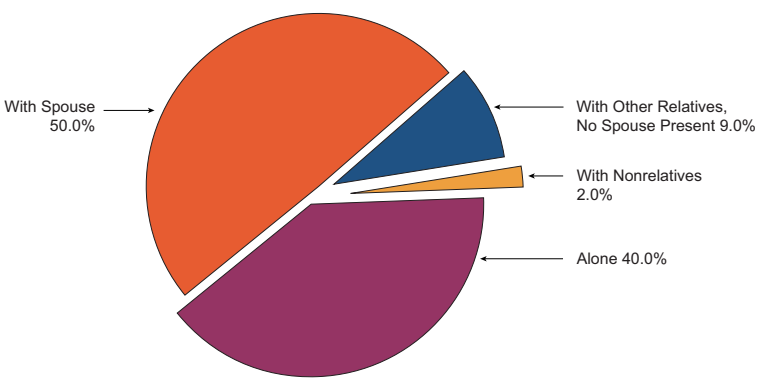
OLDER WOMEN

There are 20.8 million women age 65 and older living in the U.S. These older women are more likely to be living alone (40 percent) than older men (19 percent). The pattern of living arrangement varies by race and ethnicity with 2 percent of older non-Hispanic White women living alone, compared to 39 percent of Black women, 22 percent of Hispanic women, and 19 percent of Asian women. Variation also occurs in the likelihood of an older woman to be living with a non-spousal relative with non-Hispanic White women being the least likely to live with relatives other than a spouse (7 percent), compared to 13 percent of Black women, 25 percent of Hispanic women, and over 35 percent of Asian women. The proportion of elderly women living with a spouse or with nonrelatives did not vary substantially across racial/ethnic groups.

Racial and ethnic differences are evident in the leading causes of death for women aged 65 and older. While heart disease, cancer, and cerebrovascular diseases are the three leading causes of death for all racial/ethnic groups, diabetes is the 4th leading cause for women in all groups except non-Hispanic Whites. Among non-Hispanic Whites, Alzheimer's Disease is the 5th leading cause, but this ranks 9th for Black and American Indian women, 10th for Asian women, and 7th for Hispanic women. Hypertension and hypertensive renal disease are among the top 10 leading causes of death for Black and Asian/Pacific Islander women, 10th for Blacks and 9th for Asian/Pacific Islanders, but is not among the top 10 for the population as a whole. Chronic liver disease and cirrhosis is the 10th leading cause of death for American Indian women, but is not among the 10 leading causes in the general elderly female population.

Living Arrangements of Women Aged 65 and Over,* 2003

Source (II.24): U.S. Census Bureau, Current Population Survey



*These data refer to the civilian noninstitutionalized population.

Rank of Leading Causes of Death Among Women Aged 65 and Older, 2001

Source (II.24): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System

	White	Black	Hispanic	American Indian	Asian/Pacific Islander
Diseases of the Heart	1	1	1	1	1
Malignant Neoplasms	2	2	2	2	2
Cerebrovascular Diseases	3	3	3	3	3
Chronic Lower Respiratory Diseases	4	6	6	5	6
Alzheimer's Disease	5	9	7	9	10
Influenza and Pneumonia	6	7	5	6	5
Diabetes Mellitus	7	4	4	4	4
Nephritis, Necrotic Syndrome and Necrosis	9	5	8	8	7
Unintentional Injuries	8	*	9	7	8
Septicemia	10	8	10	*	*

*Not among the ten leading causes for this group.